



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

NURSING ASSESSMENT AND DIAGNOSIS

Effective Date: October 24, 2003

Policy #: NS-03

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I. PURPOSE:

- A. To systematically collect relevant data about the patient as the initial step of the nursing care process.
- B. To continually collect and review patient specific data throughout the patient's hospitalization.
- C. To accurately document assessment findings on an approved form in the Medical Record.
- D. To identify and prioritize the appropriate nursing diagnosis(es) which provide the focus for the development of the patient's plan of care and discharge plan.

II. POLICY:

- A. The standard of care at Montana State Hospital (MSH) is that patients receive nursing care based on a documented systematic assessment of their needs, strengths, and treatment expectations.
- B. Assessments will be completed by registered nurses (RNs) and documented on a standardized form. Assessments will be completed: 1) within 24 hours of admission to the hospital; 2) whenever there is a significant change in the patient's physical and/or mental status; 3) no less than yearly.
- C. The registered nurse will formulate nursing diagnoses based on the data collected in the nursing assessment and will prioritize these diagnoses according to the patient's needs.
- D. To the degree possible, the patient and significant others will collaborate with the registered nurse in the completion of the assessment and the formulation of the nursing diagnoses.
- E. The nursing assessment and nursing diagnoses are an integral part of the multi-disciplinary treatment planning process for each individual patient.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

- A. Registered Nurses - Complete nursing assessment and diagnosis.

V. PROCEDURE:

- A. Delegate the completion of the “Physical Characteristics” and “Orientation to the Unit” segments of the assessment form to any member of the nursing staff if so desired.
- B. Select an appropriate place to perform the assessment.
- C. Inform the patient of their mutual roles and responsibilities in the assessment and diagnosis process and encourage the patient’s participation.
- D. Utilize interview, behavioral observation, and physical and mental status assessment skills to achieve a thorough and accurate assessment of patient care needs.
- E. Assess each patient at the time of admission and continuously throughout the patient’s hospitalization as warranted by changes in the patient’s care needs through the systematic collection of data in the following areas: biophysical, psychosocial, risk/environmental, educational, and discharge planning.
- F. As possible, seek out the utilize information pertinent to the assessment and diagnosis process from, not only the patient, but also from family members, significant others, and other health care providers.
- G. Formulate conclusions about actual and/or potential alterations in the patient’s biophysical/psychosocial status and establish nursing diagnosis/problem statements.
- H. Identify nursing diagnosis/problem statements related to the specific assessment categories identified on the approved assessment form and/or the North American Nursing Diagnosis Association (NANDA) guidelines.
- I. Prioritize nursing diagnosis/problem statements based on the following factors:
 - 1. potential danger to self and others;
 - 2. physical illness requiring acute medical care;
 - 3. patient’s/significant others perception of need priority;
 - 4. assessed areas of severe, moderately severe to severe impairment/dysfunction; and
 - 5. Maslow’s Theory of Needs.
- J. Document the assessment findings and identify nursing diagnoses on the MSH Nursing Assessment Form. This information is used to establish the initial plan of care which is formulated within 24 hours of the patient’s admission. Assessment data and the initial plan of care are the basis upon which the multidisciplinary treatment plan is formulated (reference Patient Treatment Plan Policy).

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Susan Beausoleil Date
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